



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-10-5319-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ATLANTIC INSURANCE CO Box #: 05	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: Position Summary not submitted.

Total Amount Sought - \$365.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: A response was not submitted.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
03/09/10, 03/10/10, 04/05/10, 05/04/10, 05/31/10	Prescription medications and payments to Interventional Pain Management	4 prescriptions for Hydrocodone at \$129.99 each and 2 payments to pain management doctor at \$40 each for a total of \$599.96	\$365.00	\$365.00
			Total Due:	\$365.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.
4. An Explanation of benefits was not provided by either party.

Issues

1. Did the requestor submit their receipts the services in dispute in accordance with 28 Tex. Admin. Code §133.270?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted receipts shows the claimant paid for prescription medications and partial payments to the pain management physician.
2. In accordance with 28 Texas Admin. Code §133.270(b) the receipts were submitted to "Debbie" on July 23, 2010. It also appears that the CVS Patient Prescription Record was submitted to the attention of Geoffrey Zanetti on or after October 19, 2010. The respondent's representative received the DWC-060 package on October 14, 2010. The respondent did not submit any documentation to support that they did not receive the receipts from the claimant or that reimbursement was made to the claimant. According to 28 Texas Admin. Code §133.270(c) the respondent has 45 days to either deny or reimburse the claimant. Therefore, the claimant is eligible for reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$365.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$365.00 reimbursement.

Authorized Signature

Medical Fee Dispute Resolution Officer

01/04/11

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.